Use this form if you intend to hand-deliver, mail, or fax your appeal. Don't send this form as an attachment to an email.

NOTICE OF APPEAL

Provider Appeals Only

If you disagree with a decision of the Department of Labor & Industries, this form can be used to file an appeal of that decision.

You must file the appeal with the Board of Industrial Insurance Appeals **WITHIN SIXTY DAYS** of the date you receive the Department's decision concerning a workers' compensation claim or your provider number or status.

You must file the appeal **WITHIN TWENTY DAYS** of the date you receive the Department's decision concerning demands for repayment or vocational audits.

Board of Industrial Insurance Appeals
2430 Chandler Court SW
PO Box 42401
Olympia, WA 98504-2401
FAX: 360-586-5611 or 855-586-5611

*** indicates required field**

1. *Today's date: _____

2. *I wish to appeal the decision of the Department of L&I dated: _____
Attach a copy of the decision to be appealed

3. Provider Information

*Name: _____

Provider No.: _____

*Address: _____

City: _____ State: _____ Zip: _____

Phone: Email address:

4. Worker Information (If applicable)

First Name: Middle Name: Last Name:

L&I Claim No.:

5. Preparer Information (if different from above)

Preparer Name: _____

Attorney Name _____ Bar No. _____

Firm Name _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: Contact Email Address:

6. I disagree with the Department's determination because:

_____

_____

_____

7. Location

I desire to have any proceedings held in: (County) _____

Print Name: _____

Signature: _____